STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155551	A. BUILDING 00 B. WING	07/14/2011

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ROLLING MEADOWS HEALTH CARE CENTER	604 RENNAKER STREET LA FONTAINE, IN46940

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F0000	This visit was for the Investigation of Complaint IN00093406. Complaint IN00093406-Substantiated, federal/state deficiencies related to the allegation are cited at F225 and F226. Survey dates: July 13, 14, 2011 Facility number: 000447 Provider number:155551 AIM number: 100289950 Surveyor: Jeri Curtis, RN Census bed type: SNF/NF: 92 Total: 92 Census payor type: Medicare: 9 Medicaid: 57 Other: 26 Total: 92 Sample: 3 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed on July 18, 2011 by Bev Faulkner, RN	F0000	Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, record review, and interview, the facility failed to ensure an allegation of having been beaten by staff	F0225	No residents were negatively affected by this practice. A thorough investigation for the allegation by a	07/14/2011

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	and thrown onto the floor was not immediately reported to the state survey agency and other officials in accordance with state law for 1 (Resident A) of 3 residents, among the sample of 3, reviewed for abuse allegations. The facility also failed to ensure the results of the investigation were reported to the state survey agency and other officials in accordance with state law within 5 working days of the incident. Findings include: Resident (A) was observed seated in the activity room of the secured unit during the 7/13/11, 2:00 P.M., entrance tour. Resident (A) was listening as the Activity Director explained how zucchini bread was made. A dark purplish-red bruise was observed to the inner left wrist. A former neighbor (#1) of Resident (A) was interviewed by telephone at 3:05 P.M.,7/13/11, said he had visited twice since the admission to the facility, and indicated a concern of abuse to (Resident A) by facility staff. Neighbor #1 indicated Resident (A) had said 2 burly guys had sat on her for 5 hours. Neighbor #1 indicated on the second visit, 7/9/11, Resident (A) had told him the staff in the blue green uniforms had bounced		resident on the secured Alzheimer's unit of having been beaten by staff and thrown onto the floor was completed by the Administrator on 6/30/11. The allegation was found to be unsubstantiated. The allegation was reported to Indiana State Board of Health on 7/13/11. All residents who make allegations of abuse have the potential to be affected by this deficient practice as related to the appropriate reporting of allegations of abuse to the Indiana State Department of Health. Abuse allegations are thoroughly investigated by the facility. The facilities abuse policy has been reviewed and no changes were indicated at this time. Facility staff have been re-educated regarding the facility policy and procedure for abuse and reporting of unusual occurrences and will continue to be re-educated on abuse and reporting unusual occurrences at a minimum of two times a year. Investigations will be immediately reported to and reviewed by the Regional Director of Operations and/or Regional Director of Quality Assurance this will be ongoing for all investigations. All allegations of abuse will be reported to the Indiana State Board of Health. The Regional Director of Operations and/or Regional Director of Quality Assurance will initial all investigations indicating review and appropriate reporting to the Indiana State Department of Health. Any concerns noted will receive	

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	her off the wall, and had thrown her on the floor. Neighbor #1 indicated Resident (A) had recognized him and his family members and had begged them to get her out of the facility. Neighbor #1 indicated he had noticed multiple bruises on Resident (A) during the 7/9/11 visit. During a 7/13/11, 3:25 P.M., interview, the Administrator indicated Resident (A) had been unable to manage self care at home since the death of the spouse. The Administrator indicated members of the church had been doing volunteer care giving for Resident (A) at her home. The Administrator indicated the care givers noticed a decline in the condition with a failure to take medications correctly, wearing clothes inside out, and layering several pieces of clothing at one time. The Administrator indicated the care givers had also said Resident (A) would go to the garage and sit for several hours waiting on someone, unknown, to take her some where. The Administrator indicated a friend obtained power of attorney (POA) and had Resident (A) evaluated by a physician who recommended placement in a long term care facility. The Administrator indicated Resident (A) had been diagnosed with dementia, had		immediate follow-up. The Regional Director of Operations and/or Regional Director of Quality Assurance report of monitoring will be forwarded to the Quality Assurance Committee for monthly QA review and response and the plan of action will be adjusted accordingly.	

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	wandered into others rooms following admission, and had been transferred to the secured unit. The Administrator indicated Resident (A) did not want to be at the facility and had made false accusations against staff, indicating she had been hit and thrown onto the floor. The Administrator indicated Resident (A) was unable to identify specific staff members. The Administrator indicated he had done an internal investigation of the allegations and found them to be false. The Administrator indicated he had not reported the allegations to the Indiana State Department of Health, the state survey agency, because they had been determined to be false. The Administrator provided a copy of the 6/30/11, internal investigation for review on 7/13/11. Resident (A) alleged she had been beat up, cursed all night, and hit and thrown on the floor by certified nursing assistants (CNAs). The Administrator documented he had interviewed staff on duty during the alleged time frame and other residents in the secured unit. The Administrator documented the other residents denied ever having been mistreated. The Administrator indicated Resident (A) was interviewed and said she had bruising			

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	on her face and it was bleeding. The Administrator indicated bruising or blood were not present on the face. The Administrator also documented Resident (A) had said she had layed on the floor for 35 hours, "until they came and got me." The Administrator also documented Resident (A) had said she was having surgery to have her leg cut off, and had been told not to eat. Documentation indicated Registered Nurse (RN #1) had conducted a head to toe assessment on 7/1/11, and bruising was not observed. The Administrator indicated the POA was notified of the allegation on 7/1/11. Documentation indicated the POA had stated he had seen Resident (A) hit herself in the past. At 4:15 P.M., a full body assessment of Resident (A) was completed by the Director of Nursing (DoN), and Licensed Practical Nurse (LPN #1,) the wound nurse. A reddish-blue bruise was observed on the left inner wrist. No other bruises were observed. Several small petechiae were observed across the knuckles on the right hand. Resident (A) had swelling of the bilateral extremities with red streaks on the left knee. The DoN indicated the physician had examined Resident (A), diagnosed			

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	cellulitis and had ordered antibiotics. During the examination Resident (A) indicated 2 women and 2 men had picked her up, slammed her onto the floor, and she had laid for 25 hours in the cold rain. Resident (A) was unable to describe the persons who had allegedly slammed her onto the floor, or when or where the incident had occurred. The record of Resident (A) was reviewed 7/13/11, at 4:50 P.M., and indicated a 6/14/11, admission with diagnoses including, but not limited to, Alzheimer's dementia,and blindness. Resident (A) had 6/14/11,physician admission orders for Ativan (an anti anxiety) every 6 hours as necessary. Resident (A) had been assessed on the 6/27/11, Minimum Data Set (MDS), with a score of 4 out of 15 on the basic intellectual mental exam (BIMS), indicating severe cognitive impairment. The attending physician's 7/12/11, examination indicated delusional behaviors. The 6/20/11, plan of care indicated a concern of depressed mood with resulting confusion and being upset about placement in the facility. Interventions included allowing time for adjustment to new surroundings, provision of activities and seating Resident (A) with other residents who were able to converse.			

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	A 6/20/11, second concern was delusional (false belief) thinking that leg would be amputated, people were cursing her and mistreating her. The interventions included assuring all basic needs met, reassuring, and mental health services as needed. This federal tag relates to Complaint IN00093406. 3.1-28(c) 3.1-28(e)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, record review and interview, the facility failed to ensure their written polices for abuse prevention included the immediate reporting of an allegation of abuse to the state survey agency and other appropriate state agencies, in accordance with state law. The facility also failed to develop and implement an abuse prevention policy that included the submission of the results of a thorough investigation of an allegation of abuse to the appropriate state agencies within 5 working days of the allegation for 1 (Resident A) of 2 residents, among the sample of 3, reviewed for abuse	F0226	No residents were negatively affected by this practice. No residents have the potential to be affected by this deficient practice. During the time of the complaint survey the facility policy and procedure for Abuse was requested and supplied. The facility policy and procedure for Reporting of Unusual Occurrences was not requested. The policy and procedure for Abuse and Reporting Unusual Occurrences has been reviewed and no changes are indicated at this time. The facility policy and procedure for Abuse and Reporting Unusual Occurrences includes that the facility will	07/14/2011

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	allegations. Findings include: Resident (A) was observed seated in the activity room of the secured unit during the 7/13/11, 2:00 P.M., entrance tour. Resident (A) was listening as the Activity Director explained how zucchini bread was made. A dark purplish-red bruise was observed to the inner left wrist. A former neighbor (#1) of Resident (A) was interviewed by telephone at 3:05 P.M.,7/13/11, said he had visited twice since the admission to the facility, and indicated a concern of abuse to (Resident A) by facility staff. Neighbor #1 indicated Resident (A) had said 2 burly guys had sat on her for 5 hours. Neighbor #1 indicated on the second visit, 7/9/11, Resident (A) had told him the staff in the blue green uniforms had bounced her off the wall, and had thrown her on the floor. Neighbor #1 indicated Resident (A) had recognized him and his family members and had begged them to get her out of the facility. Neighbor #1 indicated he had noticed multiple bruises on Resident (A) during the 7/9/11, visit. During a 7/13/11, 3:25 P.M., interview,		ensure all allegations of mistreatment, neglect, or abuse including injuries of unknown source, are reported immediately to the Administrator of the facility and to other officials in accordance with state law through established procedures (Including to the state survey and certification agency). The Administrator and/or other officials shall notify ISDH in accordance with ISDH guidelines. Please be aware we are requesting paper compliance related to this deficiencies.	

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	the Administrator indicated Resident (A) had been unable to manage self care at home since the death of the spouse. The Administrator indicated members of the church had been doing volunteer care giving for Resident (A) at her home. The Administrator indicated the care givers noticed a decline in the condition with a failure to take medications correctly, wearing clothes inside out, and layering several pieces of clothing at one time. The Administrator indicated the care givers had also said Resident (A) would go to the garage and sit for several hours waiting on someone, unknown, to take her some where. The Administrator indicated a friend obtained power of attorney (POA) and had Resident (A) evaluated by a physician who recommended placement in a long term care facility. The Administrator indicated Resident (A) had been diagnosed with dementia, had wandered into others rooms following admission, and had been transferred to the secured unit. The Administrator indicated Resident (A) did not want to be at the facility and had made false accusations against staff, indicating she had been hit and thrown onto the floor. The Administrator indicated Resident (A) was unable to identify specific staff			

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	members. The Administrator indicated he had done an internal investigation of the allegations and found them to be false. The Administrator indicated he had not reported the allegations to the Indiana State Department of Health, the state survey agency, because they had been determined to be false. The Administrator provided a copy of the 6/30/11, internal investigation for review on 7/13/11. Resident (A) alleged she had been beat up, cursed all night, hit, and thrown on the floor by certified nursing assistants (CNAs). The Administrator documented he had interviewed staff on duty during the alleged time frame and other residents in the secured unit. The Administrator documented the other residents denied ever having been mistreated. The Administrator indicated Resident (A) was interviewed and said she had bruising on her face and it was bleeding. The Administrator indicated bruising or blood were not present on the face. The Administrator also documented Resident (A) had said she had lain on the floor for 35 hours, "until they came and got me." The Administrator also documented Resident (A) had said she was having surgery to have her leg cut off, and had been told not to eat.			

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	Documentation indicated Registered Nurse (RN #1) had conducted a head to toe assessment on 7/1/11, and bruising was not observed. The Administrator indicated the POA was notified of the allegation on 7/1/11. Documentation indicated the POA had stated he had seen Resident (A) hit herself in the past. At 4:15 P.M., a full body assessment of Resident (A) was completed by the Director of Nursing (DoN), and Licensed Practical Nurse (LPN #1,) the wound nurse. A reddish-blue bruise was observed on the left inner wrist. No other bruises were observed. Several small petechiae were observed across the knuckles on the right hand. Resident (A) had swelling of the bilateral extremities with red streaks on the left knee. The DoN indicated the physician had examined Resident (A), diagnosed cellulitis and had ordered antibiotics. During the examination Resident (A) indicated 2 women and 2 men had picked her up, slammed her onto the floor, and she had laid for 25 hours in the cold rain. Resident (A) was unable to describe the persons who had allegedly slammed her onto the floor, or when or where the incident had occurred.			

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	The record of Resident (A) was reviewed 7/13/11, at 4:50 P.M., and indicated a 6/14/11, admission with diagnoses including, but not limited to, Alzheimer's dementia,and blindness. Resident (A) had 6/14/11,physician admission orders for Ativan (an anti anxiety) every 6 hours as necessary. Resident (A) had been assessed on the 6/27/11, Minimum Data Set (MDS), with a score of 4 out of 15 on the basic intellectual mental exam (BIMS), indicating severe cognitive impairment. The attending physician's 7/12/11, examination indicated delusional behaviors. The 6/20/11, plan of care indicated a concern of depressed mood with resulting confusion and being upset about placement in the facility. Interventions included allowing time for adjustment to new surroundings, provision of activities and seating Resident (A) with other residents who were able to converse. A 6/20/11, second concern was delusional (false belief) thinking that leg would be amputated, people were cursing her and mistreating her. The interventions included assuring all basic needs met, reassuring, and mental health services as needed. The Administrator had provided the facility's 10/05, Administrative Abuse			

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	Prevention Program at 4:00 P.M., 7/13/11. The policy indicated residents had the right to be free of abuse, neglect, misappropriation of property, corporal punishment, and involuntary seclusion. Point #3 indicated comprehensive policies and procedures had been developed to aid in preventing abuse, neglect, or mistreatment of residents. The policies and procedures governed at a minimum: Protocols for employment background checks. Mandated staff training/orientation programs that included preventing abuse, neglect, or mistreatment of residents. Identification of occurrences of potential mistreatment/abuse. Protection of residents during abuse investigations. Timely and thorough investigations of all reports or allegations of abuse. Reporting and filing of accurate documents relative to incidents of abuse. Ongoing review and analysis of abuse incidents. Implementation of changes to prevent future occurrences of abuse. This federal tag relates to Complaint IN00093406. 3.1-28(a)			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROLLING MEADOWS HEALTH CARE CENTER	604 RENNAKER STREET LA FONTAINE, IN46940

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE